

July 27, 2009

Dear State Medicaid Director:

This letter provides operational guidance to States that may need additional time to complete the reporting and audit requirements as implemented in the December 19, 2008 Medicaid Disproportionate Share Hospital (DSH) final rule (73 FR 77904). The letter also clarifies the application of reporting requirements for data in past Medicaid State plan rate years as well as the auditor independence standard.

Background

On December 19, 2008, the Centers for Medicare & Medicaid Services (CMS) promulgated CMS-2198-F: Medicaid Program: Disproportionate Share Hospital Payments, with an effective date of January 19, 2009. The final rule implements Section 1001 of the Medicare Drug, Improvement and Modernization Act of 2003, requiring State reports and audits to ensure the appropriate use of Medicaid DSH payments and compliance with the statutorily imposed hospital-specific limits. In order to receive Federal financial participation (FFP) for DSH expenditures, States must submit an annual report and an independent certified audit to CMS for each completed Medicaid State plan rate year.

Pursuant to the provisions of the regulation, audits must begin with Medicaid State plan year 2005 and must be completed for the State plan rate years 2005 and 2006 no later than September 30, 2009. Each subsequent report and audit beginning with Medicaid State plan rate year 2007 must be completed by the last day of the Federal fiscal year (September 30) ending three years from the end of the Medicaid State plan rate year under audit. States must submit reports and audits to CMS within 90 days of the completion of the audit. Audits and reports for State plan rate years 2005 and 2006 are due to CMS on or before December 31, 2009. A State's failure to complete the audits and required reporting by the specified deadlines would put FFP for that State's DSH expenditures at risk.

To ensure a period for developing and refining reporting and auditing techniques, findings of State reports and audits for Medicaid State Plan years 2005-2010 will not be given weight except to the extent that the findings draw into question the reasonableness of State uncompensated care cost estimates used for calculations of prospective DSH payments for Medicaid State plan year 2011 and thereafter. After this transition period, FFP will not be available for expenditures for DSH payments that are found in the audit to exceed the hospital-specific eligible uncompensated care cost limit.

CMS Enforcement Strategy

Recently several States have indicated concern that, despite good faith efforts, they would be unable to meet the December 31, 2009 deadline for the first audit reports which pertain to 2005 and 2006 State plan rate years. These States cited a number of reasons, including the following: the rule's publication date fell outside of some state budget cycles so that those States could not plan for and budget completion of an independent audit for this year; the economic downturn has created a hardship on many State Medicaid agency budgets; States do not have the staff or financial resources to complete the 2005 and 2006 audits by year end; much of the data, particularly data related to uninsured costs and Medicaid managed care costs/payments, is currently housed entirely by hospitals; and the methodologies and calculations specified in the rule for determining costs differ from those used by the States during past Medicaid State plan rate years.

In light of these concerns, CMS has determined that it will apply a flexible enforcement strategy designed to ensure that States have sufficient time to properly implement the new requirements without undue hardship. Thus, CMS will not find a State to be out of compliance with the DSH reporting and auditing requirements for the initial (2005 and 2006) Medicaid State plan rate years until December 31, 2010. We do not anticipate any further delay of compliance enforcement, or any delay of compliance enforcement for subsequent audit years.

Even though CMS will be delaying compliance enforcement, CMS expects that States will be making good faith efforts to comply with the new requirements. We ask each State to identify, and to provide in writing to its respective CMS Associate Regional Administrator, a contact individual by September 30, 2009 to brief CMS representatives on the State's compliance status and progress. Based on those discussions, some States may be asked for detailed information about compliance efforts.

Additional Clarifications

The CMS is also using this opportunity to clarify more formally CMS' expectations with respect to reporting for past State plan rate years and the auditor independence standard.

Data

We have heard numerous concerns from States and hospitals that the audit and reporting requirements are extraordinarily burdensome in the initial years because States and hospitals cannot extract specific data for the reporting elements retroactively from the accounting systems used in prior years. When presented with these concerns, we have clarified to States that reports and audits should be based on the best available information. Our goal is that States will be able to fully and accurately report on these elements by the end of the transition period.

Generally, we expect most data elements necessary for the State to complete the DSH audit and report to be information States and hospitals already collect to assure that their DSH programs are compliant with Medicaid law. However, specific data elements required within the reports may be difficult for hospitals and States to accurately extract from existing reports and data systems for past State plan rate years. Anticipating such constraints, CMS included the transition period to allow States, providers and auditors time to refine reporting and auditing techniques. To the extent that States and hospitals are unable to report directly on elements for past Medicaid State plan rate years, they should include the best available information. During the transition period, CMS will work with States that make a good faith effort to fulfill all of the DSH reporting and auditing requirements. However, States and hospitals should be working to modify systems such that they will be able to report more exactly for each element prospectively.

Auditor Independence

A number of States have also raised concerns about the cost or difficulty in procuring an independent auditor to conduct the required independent certified DSH audit. We have advised States that there are a wide number of auditing arrangements which would be acceptable under these standards, some of which may be less burdensome and costly than the use of private auditing firms, including the use of state government auditing agencies. However, there appears to be continuing confusion about this standard among States.

Medicaid regulations at 42 CFR 455.301 define a certified independent audit in part to mean an audit that is conducted by an auditor that operates independently from the Medicaid agency or subject hospital. We read this requirement to be consistent with established standards within the auditing profession which guide auditors and their clients with respect to independence and impairments to independence that might potentially compromise the integrity of the audit. Specifically, CMS advises States to review and apply the General Accounting Office's most recent revision to Government Auditing Standard specific criteria for independence government auditing practices (<http://www.gao.gov/govaud/govaudhtml/index.html>). These standards assure integrity while allowing flexibility to States.

We appreciate States' ongoing efforts to implement the DSH reporting and independent audits requirements. If you have questions or would like additional information on this guidance, please contact Cheryl Powell, Division of Reimbursement and State Financing, Financial Management Group via email at Cheryl.Powell@cms.hhs.gov or by phone at (410)786-9239.

Sincerely,

/s/

Jackie Garner